Lincoln Financial Group®

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: **CTYMEMPHIS**	GROUP POLICY #: 000850012095;00040000100007029	Billing Division or Location: 40999;597478

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) City of Memphis			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐Male ☐Female	Marital Status: ☐Married ☐Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly $_____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage			Amount of Coverage	Total Premium
		Basic Group Life	☐Yes	☐No	$	$
		Dependent Life	☐Yes	☐No	$	$

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE			AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life Insurance	☐Yes	☐No	$	$
Voluntary Spouse Life Insurance	☐Yes	☐No	$	$
Voluntary Dependent Child Benefit	☐Yes	☐No	☐ 10,000	$

C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

E. Request for Coverages
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:
❑ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
❑ **NOT ENROLL myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
❑ **NOT ENROLL my dependents in the Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

EVIDENCE OF INSURABILITY INFORMATION

Please submit this form to The Lincoln National Life Insurance Company (herein referred to as "the Company"). No coverage for which evidence of insurability is required will be effective until approved in writing by the Company.

Complete all blanks in ink and print clearly. Incomplete forms will cause consideration for coverage to be delayed.

SECTION 1. Group Information:

Group Name	Group ID
Group Policy No(s).	Billing Division/Location

SECTION 2. Employee Information: (Complete even if employee is not applying for coverage.)

First Name_____ Last Name_____ Middle Initial_____

Social Security No. _____ - _____ - _____ State of Birth_____ Date of Birth ____/_____/_____

Annual Earnings $_____ Date of Hire/Rehire _____/_____/_____

Home Mailing Address:

_____ _____ _____ _____
(Street) (City) (State) (Zip)

Phone No(s): Home (_____) _____ - _____ Work (_____) _____ - _____ Best Time to Call _____AM/PM

Email Address:_____ Home ☐ Work ☐

Beneficiary (for Life or AD&D Insurance)_____ Relationship_____

SECTION 3. Spouse Information: (Complete only if applying for Dependent coverage.)

First Name_____ Last Name_____ Middle Initial_____

Social Security No. _____ - _____ - _____ State of Birth_____ Date of Birth ____/_____/_____

Home Mailing Address (if different than above):

_____ _____ _____ _____
(Street) (City) (State) (Zip)

Phone No(s): Home (_____) _____ - _____ Work (_____) _____ - _____ Best Time to Call _____AM/PM

Email Address:_____ Home ☐ Work ☐

SECTION 4. Plan(s) Applied for: (Only include the amount of coverage in excess of any existing amount or guaranteed issue amount.)

Basic Coverage(s)		Requested Basic Coverage Amount
Life	☐	$_____
Dependent Life	☐	$_____
STD	☐	
LTD	☐	

Optional/Voluntary Coverage(s)		Requested Optional/Voluntary Coverage Amount
Employee Life	☐	$_____
Employee Life & AD&D	☐	$_____
Spouse Life	☐	$_____
Spouse Life & AD&D	☐	$_____
Short Term Disability (STD)	☐	$_____
Long Term Disability (LTD)	☐	$_____
Critical Illness (Mark Categories below)		**Enter Principal Sum for:**
Heart Category	☐	Employee $_____
Cancer Category	☐	Spouse $_____
Organ Category	☐	Child $_____
Quality of Life Category	☐	

STATEMENT OF HEALTH

SECTION 5. Medical Information - To be completed by applicants applying for ANY coverages.

Employee Applicant	Gender: ☐ Male	☐ Female	Height: _____Ft. _____In.		Weight: _____ lbs.			
Spouse Applicant	Gender: ☐ Male	☐ Female	Height: _____Ft. _____In.		Weight: _____ lbs.			
					Employee		**Spouse**	
					YES	**NO**	**YES**	**NO**
In the past 12 months, have you smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?					☐	☐	☐	☐

SECTION 6. Medical Information - To be completed if applying for LIFE or DISABILITY coverages.

	Employee		**Spouse**	
	YES	**NO**	**YES**	**NO**
1. **Within the past 7 years**, have you had, or been told by a physician that you had, or been treated for a condition listed below? **(FOR CONDITIONS ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)**				
a. Heart or circulatory disorder; liver or kidney disorder; lung or respiratory disorder; mental or nervous disorder; alcoholism, drug or substance abuse; diabetes, cancer, tumor, epilepsy, hepatitis or stroke?	☐	☐	☐	☐
b. High blood pressure? If answered YES, please provide last reading and date of reading:	☐	☐	☐	☐
BP Reading (Employee) _____ Date _____				
BP Reading (Spouse) _____ Date _____				
c. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for antibodies to HIV (Human Immunodeficiency Virus)?	☐	☐	☐	☐
2. **Within the past 5 years,** have you been diagnosed with a physical disorder not listed above? **(IF ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)**	☐	☐	☐	☐
3. Are you currently under observation, receiving treatment or taking medication? **(IF ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)**	☐	☐	☐	☐
4. **If applying for DISABILITY coverage, please complete these additional questions.**				
a. Are you currently pregnant?	☐	☐	☐	☐
b. **Within the past 5 years,** have you been diagnosed or treated for:				
i. Disorder of the back, neck, or spine?	☐	☐	☐	☐
ii. Osteoarthritis, Rheumatoid Arthritis, or degenerative joint disease?	☐	☐	☐	☐
iii. Knee Disorder, Injury or Surgery?	☐	☐	☐	☐
(FOR CONDITIONS ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)				

SECTION 7. Provide details for any questions answered YES in SECTION 6. (Attach additional sheet, if needed.)

Question Number	Applicant Name	Condition/Treatment/Medication	Date of Diagnosis	Date of Last Symptom	Current Status or Condition	Attending Physician's Name, Address, and Phone Number

CONTINUED ON NEXT PAGE

SECTION 8. Medical Information - To be completed if applying for CRITICAL ILLNESS coverage.	Employee YES	Employee NO	Spouse YES	Spouse NO
1. **Within the past 7 years,** has anyone applying for coverage been diagnosed with or received treatment for Systemic Lupus, Type I or II Diabetes, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or sarcoidosis?	☐	☐	☐	☐
If applying for the Heart Category, please complete the questions below.				
2. **Within the past 7 years,** has anyone applying for coverage been diagnosed with or received treatment for Pacemaker, any type of fibrillation, coronary artery disease, atherectomy or any type of heart surgery, heart attack, congestive heart failure, cardiomyopathy, stroke, transient ischemic attack, congenital heart disease, chronic anticoagulation therapy?	☐	☐	☐	☐
3. Is anyone applying for coverage currently taking three or more high blood pressure (HBP) medications or had HBP medications changed or increased within the past six months?	☐	☐	☐	☐
If applying for the Cancer Category, please complete the question below.				
4. **Within the past 7 years,** has anyone applying for coverage been diagnosed with or received treatment for internal cancer, melanoma, bone marrow or stem cell transplant?	☐	☐	☐	☐
If applying for the Organ Category, please complete the question below.				
5. **Within the past 7 years,** has anyone applying for coverage been diagnosed with or received treatment for Cystic fibrosis, renal hypertension or any kidney disease or disorder (not including stones), chronic obstructive pulmonary disease, emphysema, pulmonary fibrosis, Hepatitis or liver disease or disorder (not including Hepatitis A), cirrhosis of the liver, any organ transplant, or donor?	☐	☐	☐	☐
If applying for the Quality of Life Category, please complete the question below.				
6. **Within the past 7 years,** has anyone applying for coverage been diagnosed with or received treatment for glaucoma or retinitis pigmentosa?	☐	☐	☐	☐

FRAUD WARNING. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I HEREBY:

1. request the coverage for which I am (or may become) or my Spouse is (or may become) eligible under group policies issued by The Lincoln National Life Insurance Company;
2. authorize any required deductions from my earnings;
3. name the above beneficiary to receive any benefits payable in the event of my death;
4. represent to the best of my knowledge and belief that the above Statement of Health is true and complete, and that each item answered yes is fully disclosed;
5. represent that if the above Statement of Health has been completed to obtain coverage for my Spouse, I have discussed and reviewed with my Spouse the responses and information supplied on behalf of my Spouse in the Statement of Health, and to the best of our knowledge and belief, the Spouse portion of the Statement of Health is true and complete, and each item answered yes is fully disclosed; and
6. acknowledge that I have read the **FRAUD WARNING.**

I understand that for continued eligibility I must remain an active employee working at least the minimum hours or otherwise continue coverage as outline in the contract. **The attached AUTHORIZATION has been completed and signed by the employee.**

Signature of (Employee) Applicant:_____ **Date:**_____

Signature of (Spouse) Applicant:_____ **Date:**_____

Group Insurance Service Office Use: ☐ Self Bill ☐ List Bill

Approved_____ Declined_____

EFFECTIVE DATE:_____

PLEASE COMPLETE THE ATTACHED AUTHORIZATION

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

AUTHORIZATION: I (the undersigned) authorize any physician, medical professional, medical facility, pharmacy benefit manager, insurer, reinsurer, consumer reporting agency or the Medical Information Bureau (MIB) to release information from the records of:

1. Applicant/Patient Name:_____
(Last) (First) (Middle)

Date of Birth:_____ Social Security Number:_____

This Authorization covers any periods of medical treatment during the last seven years.

2. Information to be released: My complete medical records including:
   - information about the diagnosis, treatment or prognosis of my medical condition (including referral documents from other facilities); and
   - prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources.

3. Information is to be released to: EMSI (Examination Management Services Incorporated), The Lincoln National Life Insurance Company or its reinsurers.

4. I understand that the purpose of disclosing this information is to evaluate my application for insurance. The Company will use the information obtained with this Authorization to determine eligibility for insurance; and will only release such information:
   - to reinsurance companies, the MIB or providers of a business or legal service concerned with my application; and
   - as otherwise may be required by law or may be further authorized by me.

I further understand that refusal to sign this Authorization may result in denial of eligibility for this insurance coverage.

5. I understand the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law, however, the Company contractually requires the recipient to protect the information.

6. I understand that I may revoke this Authorization in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my coverage with the Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signing. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

7. A photocopy of this Authorization is to be considered as valid as the original.

8. I acknowledge that I have received the attached Notice of Information Practices.

9. I understand that I am entitled to receive a copy of this Authorization.

Signature of Applicant:_____ **Date:**_____

NOTICE OF INSURANCE INFORMATION PRACTICES

COLLECTION OF INFORMATION

This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance coverage on a fair and equitable basis, we must collect information about you and others for whom coverage may be provided. This information may include age, occupation, physical condition, health history, prescription drug records, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, pharmacy benefit managers, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

DISCLOSURE OF INFORMATION

The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Insurance regulatory, law enforcement or other governmental authorities;
6. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
7. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

We do NOT disclose to our affiliates any information we receive about you from a consumer reporting agency. We do NOT disclose your nonpublic personal information to third parties except as necessary to provide you our products and services.

MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. We, or our reinsurers, may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact the MIB at 866 692-6901 (TTY 866 346-3642 for hearing impaired). If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

PERSONAL DISCLOSURE

Also, you have a right to access personal information about you in our files. You may request that we correct, amend or delete information you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

TELEPHONE PERSONAL HISTORY REVIEW

After your application has been received in the Group Insurance Service Office, you may receive a telephone call from a specially trained Group Insurance Service Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:
The Lincoln National Life Insurance Company
Group Insurance Service Office
P. O. Box 2616
Omaha, Nebraska 68103-2616

DETACH THIS COPY AND KEEP FOR YOUR RECORDS

Lincoln Financial Group®

Group Life Insurance

Life and AD&D

SUMMARY OF BENEFITS

Sponsored by: **City of Memphis**

Life Benefit	**Employee**	**Spouse and Dependent**
Amount	1.5 times Basic Annual Earnings, rounded to the next higher $100	$10,000 Spouse $1,000 Child: 14 days to 6 months $10,000 Child: 6 months to age 19 (to age 25 if full-time student) $2.15 Monthly Cost
Maximum Amount	$200,000	
Guarantee Issue	$200,000	

Benefit Reduction	**Employee**	**Spouse**
Benefits will reduce:	8% at age 65 An additional 8% of original amount at age 66; and An additional 7% of original amount at age 67; and An additional 6% of original amount at age 68; and An additional 6% of original amount at age 69; and An additional 15% of original amount at age 70; and An additional 16% of original amount at age 75; and An additional 11% of original amount at age 80; and An additional 7% of original amount at age 85; and An additional 5% of original amount at age 90; and An additional 5% of original amount at age 95; Benefits terminate at retirement, unless eligible for retiree benefits	Benefits terminate when employee's coverage terminates or at employee retirement

Additional Benefits

See Definitions Page:	Accelerated Death Benefit
See Definitions Page:	Conversion

Eligibility	**Employee**	**Spouse**
	All full-time employees working 30 or more hours per week in an eligible class are eligible for coverage. A delayed effective date will apply if the employee is not actively at work.	Cannot be in a period of limited activity on the day coverage takes effect.
Monthly Cost	$0.36 Monthly rate per $1,000 of coverage.	

(Please see other side)

Definitions

Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance and it will be provided at your own expense.
Limited Activity	A period when a spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Term Life	Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Exclusion: Suicide	Benefits will not be paid if the death results from suicide within 2 years after coverage is effective. May apply if employee contributes toward the premium.

Additional Benefits

***BeneficiaryConnect*℠**	Support services for beneficiaries who have experienced a loss.
***TravelConnect*℠**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information
Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Group Insurance products are issued by The Lincoln National Life Insurance Company (Ft. Wayne, IN), **which is not licensed and does not solicit business in New York.** In New York, group insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group companies. Product availability and/or features may vary by state. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. **Each affiliate is solely responsible for its own financial and contractual obligations.**

Lincoln Financial Group®

Voluntary Life Insurance

SUMMARY OF BENEFITS

Sponsored by: **City of Memphis**

Life Benefit	**Employee**	**Spouse**	**Dependent**
Amount	Choice of $10,000 increments Not to exceed 5 times your annual salary Employees age 70 and older, maximum benefit is $50,000	Choice of $5,000 increments Employee must elect coverage for spouse to be eligible. Not to exceed 50% of employee elected amount.	$250 Child: 14 days to 6 months $10,000 Child: 6 months to age 19 (to age 25 if full-time student) Newborn children to age 14 days are not eligible for a benefit Employee must elect coverage for dependents to be eligible.
Minimum Amount	$10,000	$5,000	$10,000
Maximum Amount	$500,000	$250,000	$10,000
Guarantee Issue	The lesser of $200,000 or 3 times salary under age 60 $10,000 age 60-69 No Guarantee Issue age 70 and older	$30,000 if employee is under age 60 No Guarantee Issue if employee is age 60 and older	$10,000

Benefit Reduction	**Employee**	**Spouse**
Benefits will reduce:	8% at age 65 An additional 8% of original amount at age 66 An additional 7% of original amount at age 67 An additional 6% of original amount at age 68 An additional 6% of original amount at age 69 An additional 15% of original amount at age 70 Benefits terminate at retirement, unless eligible for retiree benefits	35% at employee age 65 Benefits terminate at employee age 70 or retirement, whichever occurs first

Additional Benefits	
See Definition:	Accelerated Death Benefit
See Definition:	Portability
See Definition:	Conversion

Eligibility	**Employee**	**Spouse and Dependents**
	All full-time employees working 30 or more hours per week in an eligible class are eligible for coverage. A delayed effective date will apply if the employee is not actively at work.	Cannot be in a period of limited activity on the day coverage takes effect.

(Please see other side)

City of Memphis

Employee Semi-Monthly Premium

Life Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.

Refer to Program Specifications for your maximum benefit amounts.

Benefits and premium amounts reflect age reductions.

AGE	Semi-Monthly Rate per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
<30	0.030	$ 0.30	$ 0.60	$ 0.90	$ 1.20	$ 1.50	$ 1.80	$ 2.10	$ 2.40	$ 2.70	$ 3.00
30-34	0.035	$ 0.35	$ 0.70	$ 1.05	$ 1.40	$ 1.75	$ 2.10	$ 2.45	$ 2.80	$ 3.15	$ 3.50
35-39	0.045	$ 0.45	$ 0.90	$ 1.35	$ 1.80	$ 2.25	$ 2.70	$ 3.15	$ 3.60	$ 4.05	$ 4.50
40-44	0.075	$ 0.75	$ 1.50	$ 2.25	$ 3.00	$ 3.75	$ 4.50	$ 5.25	$ 6.00	$ 6.75	$ 7.50
45-49	0.130	$ 1.30	$ 2.60	$ 3.90	$ 5.20	$ 6.50	$ 7.80	$ 9.10	$ 10.40	$ 11.70	$ 13.00
50-54	0.190	$ 1.90	$ 3.80	$ 5.70	$ 7.60	$ 9.50	$ 11.40	$ 13.30	$ 15.20	$ 17.10	$ 19.00
55-59	0.285	$ 2.85	$ 5.70	$ 8.55	$ 11.40	$ 14.25	$ 17.10	$ 19.95	$ 22.80	$ 25.65	$ 28.50
60-64	0.470	$ 4.70	$ 9.40	$ 14.10	$ 18.80	$ 23.50	$ 28.20	$ 32.90	$ 37.60	$ 42.30	$ 47.00
65	0.845	**$ 9,200**	**$18,400**	**$27,600**	**$36,800**	**$ 46,000**	**$ 55,200**	**$64,400**	**$73,600**	**$ 82,800**	**$ 92,000**
		$ 7.77	$ 15.55	$ 23.32	$ 31.10	$ 38.87	$ 46.64	$ 54.42	$ 62.19	$ 69.97	$ 77.74
66	0.845	**$ 8,400**	**$16,800**	**$25,200**	**$33,600**	**$ 42,000**	**$ 50,400**	**$58,800**	**$67,200**	**$ 75,600**	**$ 84,000**
		$ 7.10	$ 14.20	$ 21.29	$ 28.39	$ 35.49	$ 42.59	$ 49.69	$ 56.78	$ 63.88	$ 70.98
67	0.845	**$ 7,700**	**$15,400**	**$23,100**	**$30,800**	**$ 38,500**	**$ 46,200**	**$53,900**	**$61,600**	**$ 69,300**	**$ 77,000**
		$ 6.51	$ 13.01	$ 19.52	$ 26.03	$ 32.53	$ 39.04	$ 45.55	$ 52.05	$ 58.56	$ 65.07
68	0.845	**$ 7,100**	**$14,200**	**$21,300**	**$28,400**	**$ 35,500**	**$ 42,600**	**$49,700**	**$56,800**	**$ 63,900**	**$ 71,000**
		$ 6.00	$ 12.00	$ 18.00	$ 24.00	$ 30.00	$ 36.00	$ 42.00	$ 48.00	$ 54.00	$ 60.00
69	0.845	**$ 6,500**	**$13,000**	**$19,500**	**$26,000**	**$32,500**	**$39,000**	**$45,500**	**$52,000**	**$58,500**	**$ 65,000**
		$ 5.49	$ 16.45	$ 24.67	$ 32.89	$ 41.11	$ 49.34	$ 57.56	$ 65.78	$ 74.00	$ 82.23
70-74	1.195	**$ 5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
		$ 9.75	$ 32.55	$ 48.83	$ 65.10	$ 81.38	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
75+	2.580	**$ 5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
		$ 12.90	$129.15	$193.73	$258.30	$322.88	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:

Use this formula to calculate premium for benefit amounts over $100,000.

	Age	Semi-Monthly Rate Per $1,000	X	Benefit In $1,000's	=	Semi-Monthly Cost
Example:	**35**	**.045**	**X**	**150**	**=**	**$6.75**
			X		**=**	

Dependent Children Rate = $1.00 Semi-Monthly

Premium covers all dependent children regardless of the number of children.

City of Memphis
Spouse Semi-Monthly Premium
Life Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Spouse premiums will be calculated based on the Employee's age.
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

AGE	Semi-Monthly Rate per $1,000	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
<30	0.030	$ 0.15	$ 0.30	$ 0.45	$ 0.60	$ 0.75	$ 0.90	$ 1.05	$ 1.20	$ 1.35	$ 1.50
30-34	0.035	$ 0.18	$ 0.35	$ 0.53	$ 0.70	$ 0.88	$ 1.05	$ 1.23	$ 1.40	$ 1.58	$ 1.75
35-39	0.045	$ 0.23	$ 0.45	$ 0.68	$ 0.90	$ 1.13	$ 1.35	$ 1.58	$ 1.80	$ 2.03	$ 2.25
40-44	0.075	$ 0.38	$ 0.75	$ 1.13	$ 1.50	$ 1.88	$ 2.25	$ 2.63	$ 3.00	$ 3.38	$ 3.75
45-49	0.130	$ 0.65	$ 1.30	$ 1.95	$ 2.60	$ 3.25	$ 3.90	$ 4.55	$ 5.20	$ 5.85	$ 6.50
50-54	0.190	$ 0.95	$ 1.90	$ 2.85	$ 3.80	$ 4.75	$ 5.70	$ 6.65	$ 7.60	$ 8.55	$ 9.50
55-59	0.285	$ 1.43	$ 2.85	$ 4.28	$ 5.70	$ 7.13	$ 8.55	$ 9.98	$ 11.40	$ 12.83	$ 14.25
60-64	0.470	$ 2.35	$ 4.70	$ 7.05	$ 9.40	$ 11.75	$ 14.10	$ 16.45	$ 18.80	$ 21.15	$ 23.50
65-69	0.845	**$ 3,250**	**$ 6,500**	**$ 9,750**	**$13,000**	**$ 16,250**	**$ 19,500**	**$22,750**	**$26,000**	**$ 29,250**	**$ 32,500**
		$ 2.75	$ 5.49	$ 8.24	$ 10.99	$ 13.73	$ 16.48	$ 19.22	$ 21.97	$ 24.72	$ 27.46
70+		**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:
Use this formula to calculate premium for benefit amounts over $50,000.

	Age	Semi-Monthly Rate Per $1,000	X	Benefit In $1,000's	=	Semi-Monthly Cost
Example:	35	.045	X	75	=	$3.38
			X		=	

Dependent Children Rate = $1.00 Semi-Monthly

Premium covers all dependent children regardless of the number of children.

Definitions

Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense.
Limited Activity	A period when a spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Portability	If coverage has been in force for at least 12 months, you may continue coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than total disability or retirement at Social Security Normal Retirement Age. A written application must be made within 31 days of your termination.
Term Life	Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Exclusion: Suicide	Benefits will not be paid if the death results from suicide within 2 years after coverage is effective. May apply if employee contributes toward the premium.

Additional Benefits

BeneficiaryConnect[SM]	Support services for beneficiaries who have experienced a loss.
TravelConnect[SM]	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information
Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.